

Dr. J. Williams

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

206999

STATE FILE NUMBER

FILED JUL 15 1957

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 594-B

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Missouri b. COUNTY Greene			
b. CITY (If outside corporate limits, give TOWNSHIP only) Springfield			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Springfield		
c. FULL NAME OF (If NOT in hospital, give location) Mercy Hosp.			Length of stay in lb 50 Yrs.		d. STREET ADDRESS 826 W. State		
3. NAME OF DECEASED (Type or print) OPAL			First Middle Last CHAPPELL		4. DATE OF DEATH July 4 1957		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24 1893	
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) Overland, Kansas				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Jacob Riley				14. MOTHER'S MAIDEN NAME Luella Bishop			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 497-21-5147		17. INFORMANT Address Mrs. Al Westmoreland Springfield, Mo.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cardio-vascular disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4221						INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE					
21. I attended the deceased from 6-12-57 to 7-4-57 and last saw her alive on 7-4-57 Death occurred at 3 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) J. Williams				22b. ADDRESS Springfield		22c. DATE SIGNED 7-5-57	
23a. BURIAL, CREMATION, REBURYAL (Specify) Burial		23b. DATE 7/6/57		23c. NAME OF CEMETERY OR CREMATORY Greenlawn		23d. LOCATION (City, town, or county) (State) Springfield, Mo.	
24. FUNERAL DIRECTOR H.H. Lohmeyer		ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 7-8-57		26. REGISTRAR'S SIGNATURE John Williams	

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Gene L. Loney*

Licensed Embalmer No. *47*

P. O. Address *Spfld.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.